AFTERMATH CHRONOLOGY: ADAM
Production of Draft Statement submitted to the Coroner as 'C5'[1]

18th June 1996	Adam's Inquest – commencement of the evidence	Ref: 011-016-114	
	Inquest into Adam's death opened and evidence from Constable Tester, Ms. Strain, Dr. Alison Armour, Dr. Edward Sumner, Dr. John Alexander, Mr. Patrick Keane Inquest adjourns to 21st June 1996	Ref: 011-008-024, Ref: 011-009-025, Ref: 011-010-030, Ref: 011-011-042, Ref: 011-012-079, Ref: 011-013-093	
19th June 1996	Draft Statement for the Royal prepared by Dr. Joe Gaston, refers to the Arieff paper and *"a number of renal transplants complicated by hyponatraemia leading to death in 10 (reported May 1996)"* In the light of that the draft Statement makes *"recommendations for the prevention and management of hyponatraemia arising during paediatric surgery"*: *1. Major surgery in patients with a potential for electrolyte imbalance should have a full blood picture (which includes haematocrit value) and an electrolyte measurement performed 2 hourly or more frequently if indicated by the patient's clinical condition.* *2. A serum sodium value of less than 128mmol/L indicates that hyponatraemia is present and requires intervention by the anaesthetist. A value of 123mmol/L or less indicates the onset of profound hyponatraemia and must be managed immediately.* *3. The operating theatre must have access to timely reports of the full blood picture and electrolytes to allow*	Ref: 060-018-036	DLS have confirmed the following by a letter to the Inquiry (Ref: INQ-0228-10): 1. Recommendations were drawn up for the prevention and management of hyponatraemia by those anaesthetists who would be involved in major paediatric surgical procedures. 2. The recommendations at Ref: 060-018-036 may be considered substantive in that they were drawn up by the only anaesthetists in NI who were performing such work. 3. There would have been no necessity or requirement to circulate the recommendations outside RBHSC or the Royal Hospitals Trust and

[1] Ref: 011-014-107a

	rapid intervention by the anaesthetist, when indicated" *(Emphasis added)* A subsequent version of the Draft Statement (finalised in consultation with Consultant Anaesthetists Dr. Robert Taylor, Dr. McKaigue[2] and with the subsequent approval of Dr P Crean[3]) is faxed by Dr. George Murnaghan to Brangam Bagnall & Co.[4] It refers to the: *"rare circumstances encountered in the Adam Strain case, and having regard to the information contained in the paper by Arieff et al (BMJ 1992) and additionally having regard to information which has recently come to notice that perhaps there may have been nine other cases in the United Kingdom involving hyponatraemia which led to death in patients undergoing renal transplantation"*[5] It also states: *"that the future management of patients undergoing paediatric surgery will be carefully monitored and re-appraised having regard to this information which is now available.* *In particular all patients undergoing major surgery who have a potential for electrolyte imbalance will be carefully monitored according to their clinical needs and where necessary intensive monitoring intensive monitoring of the electrolyte values will be undertaken. Furthermore, the now known complications of hyponatraemia in some of these cases*	Ref: 060-014-025	the Trust did not do so.

2 Dr. Seamus McKaigue (Consultant Paediatric Anaesthetist, Royal): See Schedule of Persons for details
3 Dr. Peter Crean (Consultant Paediatric Anaesthetist, Royal): See Schedule of Persons for details
4 At that time Brangam Bagnall & Co were acting for the Royal in the clinical negligence claim by Adam's family
5 The source of this information is the Deposition of Dr Maurice Savage (Ref: 011-015-113), who claims that he has *"discovered"* it but that the cases have not been published but told to him *"verbally"*.

	will continue to be assessed in each patient, and all anaesthetic staff will be made aware of these particular phenomenon and advised to act appropriately. *The Trust will continue to use its best endeavours to ensure that operating theatres are afforded access to full laboratory facilities to achieve timely receipt of reports on full blood pictures and electrolyte values thereby assisting rapid anaesthetic intervention when indicated"*		
20th June 1996	A 'marked up' in manuscript[6] further revised version of the draft Statement is faxed back from Brangam Bagnall & Co to Dr. George Murnaghan, which states: *"that ~~the~~ in future management of patients undergoing major paediatric surgery with potential electrolyte imbalance will be carefully monitored and re-appraised having regard to this information which is now available.* *~~In particular~~ all patients undergoing major paediatric surgery who have a potential for electrolyte imbalance will be carefully monitored according to their clinical needs and where necessary intensive monitoring intensive monitoring of the electrolyte values will be undertaken. Furthermore, the now known complications of hyponatraemia in some of these cases will continue to be assessed in each patient, and all anaesthetic staff will be made aware of these particular phenomen~~a~~ and advised to act appropriately.* *The Trust will continue to use its best endeavours to ensure that operating theatres are afforded access to full laboratory facilities to achieve timely receipt of reports on full blood pictures~~"~~*	Ref: 060-019-037 & Ref: 060-019-038	

[6] The deletions are shown struck through and the additions are shown as underlined

	and electrolyte values thereby assisting rapid anaesthetic intervention when indicated"		
	Letter from Dr. Sumner to the Coroner advising of a paper submitted for publication of 'Paediatric Anaesthesia' on a case on dilutional hyponatraemia, which he intended to publish and have Professor Arieff write an editorial: "*The Journal has a wide readership worldwide so should go some way towards enlightening people on this rare (?) occurrence"*	Ref: 011-082-217	
21st June 1996	A final version of the draft Statement is faxed at 13:06 from Brangam Bagnall & Co to Dr. George Murnaghan, which states: "*In the light of the rare circumstances encountered in the Adam Strain case, and having regard to the information contained in the paper by Arieff et al (BMJ 1992) and additionally having regard to information which has recently come to notice that perhaps there may have been nine other cases in the United Kingdom involving hyponatraemia which led to death in patients undergoing renal transplantation, the Royal Hospitals Trust wish to make it known that:* *in future all patients undergoing major paediatric surgery who have a potential for electrolyte imbalance will be carefully monitored according to their clinical needs, and where necessary, intensive monitoring intensive monitoring of their electrolyte values will be undertaken. Furthermore, the now known complications of hyponatraemia in some of these cases will continue to be assessed in each patient, and all anaesthetic staff will be made aware of these particular phenomena and advised to act appropriately.* *The Trust will continue to use its best endeavours to ensure that operating*	Ref: 059-008-024 & Ref: 059-008-025	DLS have confirmed the following by a letter to the Inquiry (Ref: INQ-0228-10): 1. This draft statement was prepared as a laymen's version of the recommendations at Ref: 061-018-036 by the Trust's management in conjunction with the Trust's solicitor. 2. Its last version on file remains labelled draft and its sole purpose was to inform the media. It was forwarded to the Trust's Director of Corporate Affairs on 21.06.95 in anticipation of media interest at the conclusion of the Inquest.

	theatres are afforded access to full laboratory facilities to achieve timely receipt of reports on full blood pictures and electrolyte values thereby assisting rapid anaesthetic intervention when indicated"		
	Adam's Inquest – continuation of the evidence: Evidence from Dr. Taylor and Dr. Savage. During his evidence Dr. Robert Taylor produced a further statement identified as 'C5', which is identical to the draft statement faxed by Brangam Bagnall & Co to Dr George Murnaghan on 21st June 1996[7]	Ref: 011-014-096 & Ref: 011-015-109 Ref: 011-014-107a for 'C5'	.

[7] See Ref: 059-008-024 (for fax sheet) & Ref: 059-008-025 (for the draft statement) NB Dr George Murnaghan's Inquiry Witness Statement goes further than that Draft Statement: *"This statement indicated that all paediatric anaesthetic staff within the Trust would be made aware of the particular phenomena associated with electrolyte imbalance, the need for careful monitoring and in particular the monitoring of their electrolyte balance"* (Ref: 018)